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In the Supreme Court of the United States

OCTOBER TERM, 1995

ROBERT C. METCALF, DIRECTOR, VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES,
PETITIONER

v.

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether, in the case of elderly, indigent patients who have been enrolled by a State in Part B of the Medicare Program, the State may limit the reimbursement paid to health care providers to the amount covered by Medicaid.

2. Whether, consistent with the Medicare and Medicaid provisions of the Social Security Act, a State may provide reimbursement for rehabilitation services to the long-term care facilities in which covered patients are located, rather than directly to the health care providers that supply the rehabilitation services.

3. Whether 42 U.S.C. 1983 provides a cause of action to health care providers seeking to challenge state reimbursement practices under the Medicare and Medicaid statutes.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	7
Conclusion	12

TABLE OF AUTHORITIES

Cases:

Bob Jones Univ. v. *United States*, 461 U.S. 574 (1983)	11
Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)	6, 7, 9
Haynes Ambulance Serv., Inc. v. *Alabama*, 36 F.3d 1074 (11th Cir. 1994)	11
Morton v. *Ruiz*, 415 U.S. 199 (1974)	7
New York City Health & Hosps. Corp. v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 113 S. Ct. 461 (1992)	11
Pauley v. *BethEnergy Mines, Inc.*, 501 U.S. 680 (1991)	8
Pennsylvania Medical Soc'y v. *Snider*, 29 F.3d 886 (3d Cir. 1994)	11
Wilder v. *Virginia Hosp. Ass'n*, 496 U.S. 498 (1990)	5, 12

Statutes and regulations:

Health Insurance for the Aged Act, Pub. L. No. 89-97, Tit. I, § 102(a), 79 Stat. 291	2
42 U.S.C. 1395 *et seq.*	2
42 U.S.C. 1395k(a)(2)(C)	4
42 U.S.C. 1395*l*(a)(1) (1988 & Supp. V 1993)	2
42 U.S.C. 1395*l*(b) (1988 & Supp. V 1993)	2
42 U.S.C. 1395r (1988 & Supp. V 1993)	2
42 U.S.C. 1395v (1988 & Supp. V 1993)	3
42 U.S.C. 1395w-4(g)(3)(A) (Supp. V 1993)	10
42 U.S.C. 1395x(g)	4
42 U.S.C. 1395x(p)	4
42 U.S.C. 1395cc(a)(2)(A) (1988 & Supp. V 1993)	2

Statutes and regulations—Continued: Page

Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301, 102 Stat. 748 ..... 3, 9
Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102(a), 103 Stat. 2169 10
Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805 3-4
42 U.S.C. 1320a-7b(d) (1988 & Supp. V 1993) 3
42 U.S.C. 1396 *et seq.* 2
42 U.S.C. 1396a(a)(10)(E) (1988 & Supp. V 1993) 3, 8
42 U.S.C. 1396a(n) 8
42 U.S.C. 1396d(p) (1988 & Supp. V 1993) 3
42 U.S.C. 1396d(p)(3) (1988 & Supp. V 1993) 8
42 U.S.C. 1983 ..... 4, 5, 7, 12
42 C.F.R.:
Pt. 407:
Sections 407.40-407.50 3
Pt. 431 4

Miscellaneous:

52 Fed. Reg. 47,926 (1987) 4
53 Fed. Reg. 657 (1988) 4
H.R. Conf. Rep. No. 1104, 100th Cong., 2d Sess. (1988) ... 4
H.R. Rep. No. 105, 100th Cong., 1st Sess. Pt. 2 (1988) 10
H.R. Rep. No. 247, 101st Cong., 1st Sess. (1989) 10

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-71) is reported at 42 F.3d 1444. The order and memorandum of the district court (Pet. App. 79-107) are reported at 838 F. Supp. 243.

JURISDICTION

The judgment of the court of appeals was entered on December 5, 1994. A petition for rehearing and sug-

gestion of rehearing en banc was denied on February 23, 1995. Pet. App. 72-73. The petition for a writ of certiorari was filed on May 22, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Persons who are at least 65 years of age or disabled, and who meet certain other eligibility requirements, are automatically enrolled in Part A of the Medicare program, a federally funded hospital insurance program. See Health Insurance for the Aged Act, Pub. L. No. 89-97, Tit. I, § 102(a), 79 Stat. 291 (codified, as amended, at 42 U.S.C. 1395 *et seq.*). Persons who are covered by Medicare Part A (and certain other persons) may purchase supplementary insurance for additional medical services under Part B of the Medicare program by paying premiums to the Supplementary Medical Insurance Trust Fund. A provider of medical services to Medicare Part B beneficiaries receives the federal Medicare payment—typically 80% of "reasonable charges" for the services rendered—and then may seek payment of the remaining amount due (coinsurance) from the patient. See 42 U.S.C. 1395*l*(a)(1), 1395*l*(b), 1395cc(a)(2)(A) (1988 & Supp. V 1993). In addition to paying coinsurance, Medicare Part B enrollees must pay a monthly premium and an annual deductible. See 42 U.S.C. 1395*l*(b), 1395r (1988 & Supp. V 1993).

Medicaid is a need-based program funded jointly by the federal government and participating state governments. See 42 U.S.C. 1396 *et seq.* Under Medicaid, health care providers receive a specified sum for covered services that is established by the State through a fee schedule or other methodology. The reimbursement rate for services to patients under the

Medicaid program is almost always less than the "reasonable charge" that is the basis for reimbursement for services under Medicare. Providers must accept the Medicaid sum as payment in full, and may not seek to recover any additional amount from patients. See 42 U.S.C. 1320a-7b(d) (1988 & Supp. V 1993).

Some persons, such as the elderly poor, are eligible for coverage under both Medicare Part A and Medicaid. Those individuals may, however, lack the funds to pay Medicare Part B premiums. Congress addressed that problem by requiring participating States to enter into "buy-in" agreements with the Secretary of Health and Human Services, under which the States enroll Medicaid recipients and others who are eligible for Medicare, and who meet statutory income and resource requirements, in the Medicare Part B program. 42 U.S.C. 1395v (1988 & Supp. V 1993); 42 C.F.R. 407.40-407.50. Medicaid funds are then used to pay those persons' Medicare Part B insurance premiums.

Initially, the only individuals who qualified for Medicare "cost-sharing"—under which state Medicaid funds are used to pay Medicare Part B insurance premiums—were those persons who were "dually eligible" for both Medicaid and Medicare. Pet. App. 86. In 1988, however, Congress broadened the class of persons potentially eligible for Medicaid-financed enrollment in the Medicare Part B program beyond "dual eligibles" to include a larger class of individuals known as Qualified Medicare Beneficiaries, or "QMBs." See Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301, 102 Stat. 748 (codified at 42 U.S.C. 1396a(a)(10)(E), 1396d(p) (1988 & Supp. V 1993)); Technical and Miscellaneous Revenue Act of

1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805; H.R. Conf. Rep. No. 1104, 100th Cong., 2d Sess. 284 (1988).

The issue in this case is how much health care providers must receive for medical services rendered to QMBs when, as is usually the case, the amount payable under Medicaid is less than the "reasonable charge" for the services that would be payable under Medicare. Since 1971, the Secretary has interpreted the provisions of the Medicaid and Medicare statutes as allowing States to limit payments for medical services rendered to dual eligibles (and, later, to QMBs) to the amount by which the state Medicaid rate exceeds the amount reimbursed by Medicare, or, in the States' discretion, to pay the full amount of "cost-sharing," which includes Medicare Part B deductibles and coinsurance costs. See generally 42 C.F.R. Pt. 431; 52 Fed. Reg. 47,926 (1987) (corrected at 53 Fed. Reg. 657 (1988)). Under that framework, the Commonwealth of Virginia has chosen to limit its reimbursement of service providers to the level of reimbursement the providers would receive under Medicaid. That decision was effectuated by an amendment to the Virginia Medicaid plan, which was approved by the Secretary. Pet. App. 9-10.

2. On June 7, 1993, respondent Rehabilitation Association of Virginia, Inc., representing various providers of rehabilitation services,[1] brought this action under 42 U.S.C. 1983 against the Director of the Virginia Department of Medical Assistance Services (petitioner here) and the Secretary of

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[1] Those services include speech therapy, physical therapy and occupational therapy. They are considered outpatient services under Medicare Part B. See 42 U.S.C. 1395k(a)(2)(C), 1395x(g) and (p).

Health and Human Services. Pet. App. 11. Respondent claimed that the Secretary's position—under which Virginia could limit the reimbursement paid for Medicaid services to QMBs to the amount allowed under the State's Medicaid program—violated the Medicaid and Medicare provisions of the Social Security Act. Respondent alleged that individuals enrolled in Medicare Part B by virtue of Medicaid payments were subject to the more generous payment provisions of Medicare Part B—*i.e.*, that the State was obligated to pay the full amount of the patient's coinsurance and deductibles, after the federal government paid the Medicare amount. *Id.* at 11, 84.

Respondent also challenged Virginia's method of reimbursement for rehabilitation services provided to QMBs who are nursing home residents. Under Virginia's state plan, reimbursement for rehabilitation services provided to those patients is made directly to the nursing home (by including the amounts in the calculation of the nursing home's Medicaid per diem rate), rather than directly to the provider of services. Respondent asserted that that method of reimbursement violated applicable Medicare and Medicaid provisions. Pet. App. 11, 84.

3. The district court ruled in favor of respondent on both issues, rejecting the Secretary's interpretation of the relevant Medicare and Medicaid provisions. Pet. App. 82-107.

4. A divided panel of the court of appeals affirmed. The court first rejected petitioner's argument that 42 U.S.C. 1983 does not provide a cause of action for alleged violations of the Medicare and Medicaid provisions. It concluded that such a defense was foreclosed by this Court's decision in *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). Pet. App. 12.

Relying on the language of the Medicaid and Medicare statutes, and on its reading of the relevant legislative history, the court next determined that QMBs should be regarded as full Medicare enrollees, notwithstanding that their enrollment is financed by state Medicaid funds. Accordingly, the court reasoned, payment must be made at the Medicare rate, and the State must pay the difference between the payment by Medicare (typically 80% of the "reasonable charge" for purposes of Medicare) and the total "reasonable charge." Pet. App. 34-35. While noting the extreme complexity of the statutory provisions at issue (*id.* at 12-13), the court concluded that it need not defer to the Secretary's interpretation of the provisions under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). In the court's view, the text and legislative history of the provisions disclosed a clear congressional intent that state co-payments under the buy-in program be "complete," and, therefore, deference to the Secretary's contrary view was not warranted. Pet. App. 34.

The court acknowledged that the House Committee Report that accompanied the 1988 amendments to the Social Security Act "state[d], in unequivocal terms, an understanding of the buy-in program such that the states did not need to pay above the Medicaid cap" (Pet. App. 29), and that the legislative history of the 1989 amendments contained similar language (*id.* at 33). The court concluded, however, that the statements contained in that history were not controlling because, in its view, they constituted "post enactment legislative history" that mischaracterized pre-existing law. *Id.* at 31.

Judge Niemeyer filed a lengthy opinion concurring in part and dissenting in part. Pet. App. 44-71. He joined in the majority's conclusion that Section 1983 provides a cause of action for respondent's claim, but would have reversed the district court's decision that Virginia's plan violated the Medicaid and Medicare provisions. Specifically, although he arrived at a somewhat different interpretation of the statutes than did the Secretary or the panel majority, Judge Niemeyer concluded that the Secretary's reading of the statutes "is nonetheless a reasonable and therefore a permissible one," to which the court owed deference under *Chevron*. Pet. App. 46.

ARGUMENT

We believe the court of appeals erred in its construction of the relevant Medicare and Medicaid provisions, and in failing to defer to the Secretary's long-standing interpretation of the provisions under *Chevron*. Nonetheless, because there is no conflict among the courts of appeals regarding the questions presented, and because the decision below does not directly conflict with any decision of this Court, further review is not warranted.

1. "The power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974). Accordingly, this Court held in *Chevron* that where Congress has not expressed its intention as to the precise question at issue, the courts are to defer to a reasonable interpretation by the agency charged with administering the program. 467 U.S. at 844. "[T]he Secretary's interpretation

need not be the best or most natural one by grammatical or other standards. Rather, the Secretary's view need be only reasonable to warrant deference." *Pauley* v. *BethEnergy Mines, Inc.*, 501 U.S. 680, 702 (1991) (citation omitted).

a. Contrary to the court of appeals' conclusion (Pet. App. 12-38), the statutory provisions at issue in this case are, at least, ambiguous as to whether States must provide reimbursement to providers for services they render to QMBs in an amount that ensures that the total reimbursement received by the providers will be the amount that they would receive under Medicare Part B. Pet. App. 86. Under 42 U.S.C. 1396a(a)(10)(E) (1988 & Supp. V 1993), a state Medicaid plan "must" make Medicaid funds available for Medicare cost-sharing on behalf of QMBs. "Medicare cost-sharing" is defined in 42 U.S.C. 1396d(p)(3) (1988 & Supp. V 1993) to include Part B premiums, coinsurance, and deductibles, as well as "[t]he difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent.'" The court of appeals read that provision as creating an affirmative obligation on the part of the States to pay *in full* all Medicare Part B premiums, coinsurance, and deductibles for QMBs. Pet. App. 22, 36-38. That language, however, provides only that, under certain circumstances, the State is obliged to pay premiums, deductibles, and coinsurance. It does not specify whether the State must pay the coinsurance amount to the extent it would exceed the generally applicable payment ceilings under Medicaid. In contrast, 42 U.S.C. 1396a(n), on which the Secretary and petitioner relied below, is pertinently

titled "Payment amounts," and *permits*, but does not require, a state plan to make payments in excess of amounts paid under Medicaid. That Section expressly provides that "the State [Medicaid] plan *may* provide payment in an amount * * * exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals." *Ibid.* (emphasis added).

Taken together, those provisions support the Secretary's construction and, at the very least, demonstrate that Congress did not intend to mandate the contrary position adopted by the court of appeals. In light of that textual ambiguity, and the "technical and complex" nature of the programs at issue, see *Chevron*, 467 U.S. at 865, the court of appeals erred in failing to defer to the Secretary's interpretation of the provisions.

b. The legislative history of the relevant provisions strongly supports the Secretary's interpretation. In 1988, Congress enacted the Medicare Catastrophic Coverage Act, Pub. L. No. 100-360, § 301, 102 Stat. 748, which required participating States to provide Medicare cost-sharing to dual eligibles. The House Committee Report that accompanied that legislation acknowledged the existence of an optional "Medicaid cap" on reimbursements to providers serving those individuals, and expressed the intention that that system would continue under the amended legislation:

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligibles, some States pay the coinsurance even if the amount that Medicare pays for the service is higher than the State Medicaid payment rate,

> while others do not. *Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare—i.e., 80 percent of the reasonable charge—exceeds the amount Medicaid would pay for the same item or service.* However, if a State chooses to pay some or all of the coinsurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

H.R. Rep. No. 105, 100th Cong., 1st Sess. Pt. 2, at 61 (1988) (emphasis added).

Similarly, when it passed the Omnibus Budget Reconciliation Act of 1989 (OBRA), Pub. L. No. 101-239, § 6102(a), 103 Stat. 2169, Congress was aware of, and deliberately left intact, the Secretary's construction of the cost-sharing provisions. OBRA included the enactment of 42 U.S.C. 1395w-4(g)(3)(A) (Supp. V 1993), which provides that "[p]ayment for physicians' services" to dual eligible patients and QMBs "may only be made on an assignment-related basis." Under Medicaid, a provider who receives reimbursement on the basis of an assignment of the claim from the patient cannot seek reimbursement beyond what is made by the State under Medicaid. The House Committee Report on the 1989 legislation explained that because "the Medicaid rules that result in assignment being accepted for all dual eligibles are not applicable to qualified Medicare beneficiaries * * *, physicians are able to bill these patients directly and to charge amounts in excess of what Medicare determines to be reasonable and what Medicaid will reimburse." H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989). The House Committee

Report expressly recognized that state Medicaid programs "typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question." *Ibid.* With that background in mind, OBRA was intended to "codif[y] the current practice with respect to dual eligibles and extend[] it to qualified Medicare beneficiaries. *It does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims.*" *Ibid.* (emphasis added).

Congress's repeated expansion of the cost-sharing provisions, with full cognizance of the Secretary's long-standing construction of that program, "make[s] out an unusually strong case of legislative acquiescence in and ratification by implication of" the Secretary's position. *Bob Jones Univ.* v. *United States*, 461 U.S. 574, 599 (1983). In light of that history, the court of appeals' substitution of its own interpretation for that of the Secretary was error.

2. Although, in our view, the court of appeals erred in failing to defer to the Secretary's reasonable interpretation of the Medicaid and Medicare provisions, this case does not warrant further review. Each of the other courts of appeals that have considered the question has rejected the Secretary's position. See *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 113 S. Ct. 461 (1992); *Haynes Ambulance Serv., Inc.* v. *Alabama*, 36 F.3d 1074 (11th Cir. 1994); *Pennsylvania Medical Soc'y* v. *Snider*, 29 F.3d 886 (3d Cir. 1994). Because there is no conflict among the circuits, and because the court of appeals' decision does not directly conflict with any

decision of this Court, certiorari is not warranted at this time.

Two newly filed cases raise the same issue of statutory interpretation in other circuits. See *Michigan Ass'n of Ambulance Servs.* v. *Michigan*, No. 5:95-CV-48 (W.D. Mich.); *Paramount Health Systems* v. *Wright*, No. 95-C-1620 (N.D. Ill.). Should the Secretary's position prevail in one or more of those cases, this Court's review might become warranted.[2]

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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[2] Petitioner's other claims do not merit further review. The district court, incorrectly we believe, invalidated Virginia's direct-payment rule. However, that issue is not of national importance, and may be remedied by the State without recourse to the Court. Petitioner's contention that, notwithstanding this Court's decision in *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498 (1990), 42 U.S.C. 1983 does not provide a cause of action to health care providers seeking to challenge a State's alleged failure to comply with the Medicare and Medicaid provisions at issue here, likewise has not given rise to a circuit conflict that would warrant resolution by this Court.